STATE OF NEW HAMPSHIRE

DEPARTMENT OF SAFETY

DIVISION OF FIRE STANDARDS & TRAINING

BUREAU OF EMERGENCY MEDICAL SERVICES

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TRAUMA MEDICAL REVIEW COMMITTEE

COMMITTEE MEETING

December 17, 2003
Richard M. Flynn Fire Academy
Concord, New Hampshire

Members Present: John Sutton, MD, Richard Johnson, MD, Elisabeth Burns, Eileen Corcoran, RN, Kathy Bizarro

Guests: Donna York Clark, RN, Janet Houston, Vanessa Barrett, RN, Melissa Twomey, RN, John Leary, RN,EMTP, Karen McBride, RN, Tony Corum, EMTP, Vicki Blanchard, EMTP

Bureau Staff: Sue Prentiss, EMTP, Clay Odell, EMTP, RN, Fred von Recklinghausen, EMTP

I. Call to Order

Item 1. The December meeting of the Trauma Medical Review Committee was called to order by Dr. Sutton at 9:38 am on Wednesday December 17, 2003 at the Richard M. Flynn Fire Academy in Concord, NH.

Clay Odell introduced three individuals who have been nominated by their respective organizations for membership on the TMRC. The nomination letters and supporting documents were sent last week to Commissioner Richard M. Flynn's office. Nick Mercuri will be representing the NH Association of EMT's, Tony Corum will be representing the NH Paramedic Association and Karen McBride will be representing the NH Medical Examiner's Office. Clay also clarified that Mike Pepin had been appointed to the TMRC by Commissioner Flynn prior to the October meeting.

II. Acceptance of Minutes

Item 1. **Minutes**. The minutes of the October meeting were not approved prior to the meeting because some members did not respond to the emails Clay sent out. The minutes were reviewed by the members in attendance and approved as written.

Committee Discussion Items

Item 1. **NH EMS Update** Bureau Chief Sue Prentiss presented a report on Bureau activities. That report is attached to these minutes.

Item 2. Trauma Coordinator's Report Clay Odell reports the NH BEMS has been participating in the Enhanced EMS / Emergency Public Health Training Program being lead by Dr. Joseph Sabato. As previously reported, this program is intended to train EMS providers in injury prevention. The program is designed as a nine-month module, beginning with six weekly day-long classes followed by the participants' establishment of an injury prevention initiative in their community. The program is also receiving support from Keene State College and is being funded by a grant from NHTSA.

On December 3, 2003 the group held a one-day workshop at the NH Fire Academy in which participants were introduced to the concept of EMS/Fire service based injury prevention. Several examples of successful EMS/Fire injury prevention initiatives were presented. The participants were invited to participate in the full program which will be starting in January 2004. Approximately 20 people attended the workshop and a majority expressed an interest in taking the full course.

Dr. Sutton expressed admiration for the effort, but expressed concern about what appeared to be an arduous program. Are people not participating because the program is too lengthy and would a different method of delivering the material be more attractive to EMS providers? Is there any way to require a certain number of providers within a region be certified in injury prevention? Sue Prentiss discussed the concept of injury prevention being part of an EMS career ladder. There is still much to be done to develop a culture of injury prevention in EMS.

Vanessa Barrett asked if this effort was integrated with other IP efforts in the state, such as hospital programs. That is certainly the intention of the NH BEMS.

Clay advised that the American College of Surgeons Committee on Trauma is projecting a 2004 release of the revised edition of the "Resources for the Optimal Care of the Injured Patient". This will likely play into the projected revision of the NH Trauma Care Plan. In addition John Sutton advised that we may wish to consider consolidation of the pediatric component of the NH Trauma Plan while still keeping the unique aspects of the pedi plan. Dr. Sutton also feels that the TMRC shouldn't delay a revision of the NH Trauma Plan waiting for the ACS document to be published. The ACS plan is a good template, but has many requirements that were considered excessive by the TMRC in drafting the original plan for NH.

Dr. Richard Johnson expressed a concern regarding the provision of anesthesia services to very young children. Anecdotally there have been anesthesiologists who expressed a disinclination to anesthetize children less than 3 months of age. This has the strong potential for affecting the provision of emergent surgical intervention in this age group. He believes the TMRC should be alert for any trend of this nature and be prepared to address it early. Donna Clark says more often than not, when DHMC's critical care transport team arrives to transport a young child, the child's airway is not secured prior to their arrival. Dr. Sutton suggested that we might want to survey the

trauma hospitals to find out their level of capability and willingness to deal with very young children.

Item 3. **TEMSIS** EMS agencies who are having members of their staff participate in the Enhanced EMS / Public Health Training Program will be the primary agencies participating in the Beta test of the electronic reporting system. The timeline for this beta test is early in 2004, although the trauma grant does not fund implementation, only planning.

Item 4. **Trauma Conference** Clay Odell discussed the evaluations of the 3rd Annual Trauma Stakeholder's Conference. The speakers were rated very highly for the most part, although the speaker on air medical utilization was considered too dry and too full of studies and statistics for many attendees. Participants were very pleased with the selection of topics.

In general the comments were very positive. There are many suggestions of topics to cover at future conferences. Many members of the TMRC attended and 22 of the 26 hospitals in the state were represented. There were 93 attendees.

The breakout sessions were a very positive experience. This was a very good opportunity to listen to the concerns of the stakeholders in the trauma community.

The episodic resource deficiencies session was intended to discuss what kinds of problems different facilities are experiencing with staffing or other resource shortages that occur sometimes but not always in the initial treatment of serious trauma patients. (See attached)

Dr. Sutton discussed a concept of transferring trauma patients back to their local hospital once their condition has stabilized to the point that they don't require the care of the Level I facility, but still require hospitalization. This idea would enable a patient to be closer to home, enable community hospitals to keep up the capability of caring for patients who have received significant trauma, and free up resources at the Level I facility. Drawbacks to this concept are reimbursement issues and surgeons willingness to take on the care of these patients.

On-call physician capabilities were discussed in this session. Telemedicine technology was discussed.

The trauma transfer breakout session brought out issues such as the perception of multiple participants that the procedure to get a patient transferred to DHMC was difficult. DHMC is working on making this process more clear for the sending facilities, because the problem mostly lies with the sending facility calling the wrong service, such as Neurosurgery.

Individuals in the session for the most part did not know if their facility had policies and procedures in place concerning what kinds of patients to transfer and how to

consistently go about transferring them. The consensus of the group was that such policies would be a good tool to have. Many hospitals have those policies, but staff members may not know where to find them.

Donna Clark initiated a discussion about the usefulness of sending out a monthly communication from the NH Trauma System to answer questions, send out information and keep the lines of communication open. Sue Prentiss reports that a requirement of the federal trauma grant is to have a listserve in place by March 2004 for trauma stakeholders in NH, and we are working on getting approval by the state library. Dr. Johnson expressed that he and many others are already on email information overload. He suggests physical presence, friendliness and accessibility are important.

Vanessa Barrett asked about the availability of feedback from the receiving facility to facilitate an improvement in care. Dr. Sutton indicated in his experience the process required a significant amount of diplomacy because some people consider it as beneficial constructive criticism and others are offended by it. Dr. Sutton felt that the process could be done better through Clay by establishing a rapport with the people involved and explaining that this is a very positive process and conducting it in a non-threatening way.

The idea of sending out a “question of the month” to hospital trauma coordinators, who then approach the appropriate individuals at their facility to get their input into the topic. Feedback from the trauma coordinators will then be distributed to all the other trauma coordinators to disseminate ideas, suggestions, etc.

The hospital emergency preparedness breakout session included a discussion about small- and large-scale decontamination at hospitals and the efforts that the NH Hospital Association has lead to identify the needs and plan for enhanced equipment and training for hospital decon.

Further discussion about the breakout sessions was deferred to future meetings due to time constraints.

Item 5. Legislative Action Newspapers in NH reported that the NH Police Chiefs Association is studying and considering initiating legislation regarding mandatory seatbelt laws in NH. When that effort is initiated it would be important for the TMRC to reach consensus regarding the initiative and draft a response to Commissioner Flynn in support of the initiative.

Item 6. Subcommittee - Renewal of Hospital Assignment Clay Odell distributed a draft of the application for renewal of trauma hospital assignment. The draft incorporates suggestions and modifications made by the TMRC following the presentation of the work of the reassignment subcommittee at the October TMRC meeting.

Janet Houston suggested that a question be added to the application requesting information regarding the facility's mass casualty plan. There is no requirement for mass casualty plans in the current NH Trauma System Plan, so such an item could not be used as criteria for approving or denying renewal of assignment. Some of the attendees said that mass casualty plans are an issue that the NH Trauma System should advocate and take a leadership role in. Perhaps adding a question regarding this issue would indicate to the hospital that the NH Trauma System considers mass casualty planning important. Other attendees asked what we would do with the information we received, and if we don't have a clear use for the information does the inclusion of such a question complicate the application process? The consensus of the group was to add a question of this nature as an addendum to gather information and assist the TMRC with future changes to the NH Trauma Plan.

There was a discussion about whether the questions we are asking give us the ability to observe changing trends in the delivery of trauma care. Should we ask questions about which types of patients your facility transfers? The NH Trauma Plan requires the facility to provide policies of trauma admission criteria.

Dr. Sutton recommended wording in the cover letter saying that the TMRC recognizes that practice styles, personnel availability, etc. have changed since the original document and review and an important part of the renewal process is identifying what the reality of the current situation is. Specifically under question #6 if there are things that have changed for the applicant since the last review the TMRC would like the facility to bring those changes forward for consideration.

Under performance improvement ask the question do you have a trauma registry, and if so what do you do with the information?

The TMRC discussed the process once a renewal application arrived. Consensus was that the Trauma Coordinator and either the Chair of the TMRC or another representative of the TMRC review the application, address needs for clarification and present the application for approval by the TMRC. The TMRC feels there is continued benefit in having representatives from the TMRC go to the applicant hospital at some point in the process for consultation-type conversations and to assure that the NH Trauma System is still active. This activity would be significantly reduced from the original site visit activities.

Janet Houston said that one problem with asking mostly open-ended questions was a difficulty ensuring consistency between different hospitals. She recommended making the questions more objective. Dr. Sutton decided that he and Clay would meet to revise the questions. It seemed that the first five questions were already pretty specific, the matrix was okay, but performance improvement questions could be improved. One area of consistent difficulty is obtaining evidence of surgeon's CME. That would be useful to know, but is difficult to acquire.

Sue Prentiss recommended that the application packet go out as a CD or some electronic version that be completed on the computer and sent in electronically. It should also have timelines/deadlines.

III. Old Business

Item 1. Air Medical Notification Project Donna Clark reports that DHART and UMass Lifeflight is still working with Monadnock Community Hospital to conduct safety training. Dr. Chris Fore has expressed interest in the Concord area participating. Frisbie Memorial Hospital has expressed interest in participating and will be in contact with Lifeflight of Maine.

Donna reported that from October 1, 2001 to October 1, 2002 seventy roadside trauma responses were completed. In October 2002 to October 2003 ninety-two roadside trauma responses were completed. Total completed DHART air transports in FY 2003 were 760 flights. Transports of trauma patients (interfacility and scene responses) were 40% of total flights.

There was a discussion about how to address a certain incident in which one of the members attending the meeting was aware of that involved a very lengthy extrication and transport by ground to a Level 2 facility who then immediately requested air medical transport, but the patient expired. The questions are why was air medical transport not requested from the scene and who does one contact to review the decision making on the call?

The group identified individuals to contact regarding a review of the incident, but further discussed the problem of a lack of consistent hospital EMS medical director's review of air medical notification in the context of protocols for serious trauma. Medical directors should consider air medical notification in the same context as other procedures in a protocol and question the exclusion of air medical consideration as a protocol violation. Hospital EMS QI should not only routinely review cases of serious trauma but emphasize the consideration and use of air medical resources.

Item 2. System Performance Improvement Project Fred von Recklinghausen reported that he met with Heather Page to conduct a quick review of the head trauma statistics from Concord Hospital to get a ballpark idea whether the numbers from the previously reported NH Head Injury / Neurosurgical Procedures Study were valid. He said the numbers looked good. Eileen Corcoran indicated that Fred was welcome to meet with Jim Wheden to review statistics from DHMC's trauma registry.

IV. New Business

None

V. Public Comment

None

VI. Adjournment

Dr. Sutton adjourned the meeting at 11:45. He advised the group that the next meeting of the Trauma Medical Review Committee will be held at the Richard M. Flynn Fire Academy on Wednesday February 11, 2004.